MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION				
Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? (X) Yes () No			
Requestor's Name and Address East Harris County Orthopedics Assoc.	MDR Tracking No.: M4-03-6797-01			
9343 N. Loop E. #600	TWCC No.:			
Houston TX 77029	Injured Employee's Name:			
Respondent's Name and Address Insurance Co of the State of PA c/o Crawford	Date of Injury:			
505 W. 12th Austin TX 78701 c/o Box 19	Employer's Name: Sodexho Inc			
Austri IA 70701 C/0 B0x 19	Insurance Carrier's No.: 003960000852600001			

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due	
From	To	Cr r Couc(s) or Description	Amount in Dispute	Amount Duc	
9-18-02	9-18-02	99214	71.00	0.00	
10-16-02	10-16-02	99214	71.00	0.00	
10-16-02	10-16-02	99090	200.00	108.00	

PART III: REQUESTOR'S POSITION SUMMARY

Carrier is denying 99214 as global to 20974. 20974 is noninvasive (nonoperative) with zero FUD per the MFG.

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier denied payment because the HCP improperly unbundled his services; an office visit is part of the surgery procedure.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The 1996 Medical Fee Guideline applies to the disputed dates of service. Carrier denied 99214 as global. Surgery ground rule I. A. states that the global reimbursement includes the pre-operative care, surgical procedure, and post-operative care. Code 20974 is listed in the surgery section so surgical ground rules apply. Therefore, office visits are not billed separately and no reimbursement recommended.

Code 99090 was denied as exceeding the fee schedule. Fee schedule MAR is \$108.00. Recommend reimbursement of \$108.00.

PART VI: DETAIL FINDINGS (If needed)

Date of		Amount in	Amount	Date of		Amount in	Amount			
Service	CPT Code	Dispute	Due	Service	CPT Code	Dispute	Due			
						Left Column:	\$0.00			
					Total A	Amount Due:	\$0.00			
DADT VII. CO	MMISSION DECI	SION AND ODDE	'D							
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					w Division has c RDERS the insur					
				•	vithin 20-days of					
•				•	•	•				
Ordered by:										
					1-3	1-05				
Authorized Signature Typed		Name Date of Order								
PART VIII: YOUR RIGHT TO REQUEST A HEARING										
Either party to	this medical d	ispute may disa	gree with all or	part of the Dec	cision and has a	right to request	t a hearing. A			
request for a h	earing must be	in writing and th	ne TWCC Chief	Clerk of Proce	edings/Appeals	Clerk must recei	ve it within 20			
days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care										
provider and placed in the Austin Representatives box on This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box										
(28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals										
Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the										
request.										
The party appe	ealing the Divis	ion's Decision s	hall deliver a co	opy of their writ	tten request for a	hearing to the	opposing party			
involved in the					•	C				
Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.										
PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION										
I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.										
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Signature of	Insurance Carrie	er:			Date:					